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CLIENT AGREEMENT FORM

I understand that:

- The Senior Health Information Program (SHIIP) is a state-sponsored, *non-profit* program for Medicare beneficiaries, persons about to be eligible for Medicare, and persons interested in long term care insurance information.
- Counseling services are intended to *help me understand* Medicare, Medicare supplement insurance, long term care insurance, and other health insurance options in an objective manner that supports my independent decisions.
- Counseling services are provided by trained volunteer counselors acting in good faith, to provide information about health insurance policies to me, the client. This information shall not be construed to be legal advice.
- Trained volunteer counselors are neither affiliated with the insurance industry nor financial planners. Counselors do not sell, recommend, or endorse any specific insurance product, agent, insurance company or provider of service.
- Counseling is confidential and free of charge.
- The volunteer *counselor assumes no responsibility* for decisions nor actions taken by me, as a result of counseling.

I, therefore, hold harmless the Senior Health Insurance Information Program, the Indiana Department of Insurance, the Indiana Family and Social Services Administration, the State of Indiana, the Sponsoring Organization, and the volunteer counselor, for any losses, claims, costs, damages, or liability arising out of or in connection with any act or omission of the volunteer counselor, the Sponsoring Organization, the State of Indiana, the Indiana Family and Social Services Administration, the Indiana Department of Insurance, and SHIIP, in connection with this Agreement.

Client's Signature

Date

Counselor's Signature

Date

POLICY RETURN LETTER

Date: _____

Insurance Company: _____

Address: _____

Re: Your Policy Number: _____

The enclosed policy was received by me on _____.
After examining the policy, I am not satisfied with it and request a full
refund in the amount of \$_____ that I paid on _____.
(Date)

Respectfully Yours,

Client's Signature

Client's Name: _____

Address: _____

Note to Client: Be sure to enclose your policy, a copy of your receipt or cancelled check, and keep a copy of this letter for your records.

INDIANA DEPARTMENT OF INSURANCE
CONSUMER SERVICES DIVISION
311 West Washington Street, Suite 300
Indianapolis, Indian 46204-2787
(317) 232-2395 or (800) 622-4461

INSURANCE COMPLAINT FORM

In response to your request for assistance, please fill out this complaint form and return it to the above address.

COMPLETE BOTH SIDES OF THIS FORM.
TYPE OR PRINT CLEARLY IN BLACK INK.

Your Name: _____

Your Address: _____

City _____ State _____ Zip Code _____

Daytime Telephone Number: (_____) _____

1. (A) Type of Insurance (Please Check One) :

☐ Automobile ☐ Homeowners ☐ Fire ☐ Life

☐ Health ☐ Medicare Supplement ☐ Business ☐ Other

1. (B) If your complaint is about a Medicare Supplement policy, please give type of policy
(A through L) _____

2. My complaint is against:
Name of Insurance Company _____

3. If an agent is involved, please give the agent's name and address.

Name: _____

Address: _____

4. Policy Number: _____

Claim Number (If known): _____

5. Named Insured: _____

6. If group insurance, please give the name of employer.
Name: _____

7. If a loss or an accident is involved, please give the location and/or date of the loss:
Date: ____/____/____

Location: _____
City _____ State _____ Zip Code _____

[illegible]

Date: ____/____/____ Signature: _____

Signature: _____

IF YOU HAVE ANY QUESTIONS, PLEASE CALL US

SHIP’S Claims Record Form

		Medicare								Medicare Supplement		Balance of Bill		
Provider of Service (Doctor, hospital, etc)	Date of Service	Assign-ment? Y or N	Actual Charge	Medicare Approved Amount	Limit-ing Charge	Applied to Medicare Deductible	Amount paid by Medicare	Amount of bill leftover	Date bill sent to Med-Sup	Amount paid by Med-Sup	Amount paid upfront to Provider	Balance due to Provider	Date balance paid to Provider	
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